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FEATURES OF COMMUNICATION OF A DOCTOR WITH SPECIAL GROUPS OF PATIENTS AND IN CONFLICT SITUATIONS

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Ключевые слова: *коммуникация в лечебном процессе, психологические особенности больных*

Abstract. Features of communication of a doctor with special groups of patients and in conflict situations. Usenko L.V., Krishtafor A.A., Tiutiunnyk A.H., Petrashenok Ye.V., Oleniuk D.V., Machuzhak H.A., Skulinets O.B. *The article describes an important component of the medical process, which should be paid a special attention: the preparation of a young doctor - the communication between the physician and the patient and his relatives. Distinctive features of a modern patient: the tendency to control the state of his own health while simultaneousl irresponsible attitude towards it; when revealing a disease, he/she is looking for the worst in himself/herself; the reduction of the moral character against the background of a decline in the morals of society, which affects the culture of the patient's behavior, makes him/her more aggressive; a modern patient is more lenient to himself/herself with an extremely demanding attitude to the doctor. Several interrelated functions of communication are distinguished: informational, interactive, perceptual, emotive (affective-commutative). The levels of communication are distinguished: social-role (ritual); business; intimate-personal. There are three types of communication: imperative; manipulative; dialogical (based on equal partnership). In the process of communication of the physician with patients, depending on the circumstances, two systems of communication can be used: verbal and nonverbal. In the relationship "patient-physician" R. Witch identifies 4 models: paternalistic, technocratic, collegian, and contractual. Each patient needs an individual approach, individual forms of communication and measures of physician's psychotherapeutic influence, especially in the communication of the doctor with so-called "difficult" patients, as well as at the risk of conflict situations. Causes of conflict situations are: insufficient attention to the patient; characteriological features of a doctor and a patient; unreliable information about the state of health of the patient from the part of junior and middle medical personnel; lack of patients information consent for treatment; lack of coordination of the actions of different medical specialists; defects in the maintenance of medical records; professional incompetence.*

Реферат. Особливості спілкування лікаря з особливими групами хворих і в конфліктних ситуаціях. Усенко Л.В., Кріштафор А.А., Тютюнник А.Г., Петрашенок Є.В., Оленюк Д.В., Мачужак Г.А., Скулінець О.В. *У статті звертається увага на важливий компонент лікувального процесу, якому треба приділяти особливу увагу при підготовці молодого лікаря — комунікацію між лікарем та хворим і його родичами; вказуються особливості сучасного хворого; наводяться дані щодо функцій, типів, систем і моделей спілкування; розглядаються особливості спілкування з «тяжкими» пацієнтами, а також причини конфліктних ситуацій та деякі способи їх усунення. Відмітні риси сучасного хворого: схильність до контролю за станом власного здоров'я при одночасному безвідповідальному ставленні до нього; при виявленні захворювання шукає в себе найгірше; погіршення морального обличчя на тлі падіння моралі суспільства, що відбивається на культурі поведінки хворого, робить його більш агресивним; сучасний хворий більш поблажливий до себе при надзвичайно вимогливому ставленні до лікаря. Виділяють декілька взаємопов'язаних функцій спілкування: інформаційну,*

інтерактивну, перцептивну, емотивну (афективно-комунікативну). Розрізняють рівні спілкування: соціально-рольовий (ритуальний); діловий; інтимно-особистісний. Виділяють три типи спілкування: імперативне; маніпулятивне; діалогічне (засноване на рівноправності партнерів). У процесі спілкування лікаря з хворими залежно від обставин може бути використано дві системи спілкування: вербальна і невербальна. У взаємовідносинах «лікар-пацієнт» Р.Вітч виділяє 4 моделі: патерналістську, технократичну, колегіальну і контрактну. Кожному хворому потрібен індивідуальний підхід, індивідуальні форми спілкування та заходи лікарського психотерапевтичного впливу, особливо в спілкуванні лікаря з так званими тяжкими хворими, а також при ризику розвитку конфліктних ситуацій. Причини конфліктних ситуацій: недостатньо уважне ставлення до хворого; характерологічні особливості лікаря і хворого; витік недостовірної інформації про стан здоров'я хворого з боку молодшого й середнього медичного персоналу; відсутність інформаційної згоди хворого на лікування; відсутність узгодженості дій лікарів різних спеціальностей; дефекти ведення медичної документації; професійна некомпетентність.

In the work of a doctor of any specialty the problem of communication with the patient and his relatives is one of the important and far from easily solved, therefore, the issues of interpersonal communication throughout the treatment process should be given sufficient attention when preparing a young doctor.

Each sick person is distinguished by his/her own characteristics: psychological state, habits, level of culture, reaction to the environment which is greatly impacted by the time in which he/she lives.

Time changes people and, naturally, patients change according to the level of development of society.

The current time is characterized by intensive urbanization which leads to constant pressure, overload, stress, lack of time, excess of information and other undesirable effects, causing neurotization and even psychopathization of the population [7, 10].

This is the unfavorable background against which somatic diseases develop and which causes the following distinctive features of a modern patient:

• a tendency to self-control over the state of one's own health while at the same time irresponsible attitude to it: alcohol consumption, drugs, smoking, overeating, watching TV for a long time and operating a computer, which reduces physical activity;

• when a disease is detected, he/she searches for the worst in himself/herself, which is partly facilitated by current medical propaganda. In some cases, especially in cancer, this may be accompanied by various functional disorders;

• a decrease in moral character against the background of a decline in the morals of society, which affects the culture of his/her behavior at home, in the street, in public transport, in the hospital, in public places makes him/her more aggressive;

• a modern patient is more lenient to himself with an extremely demanding attitude to the doctor. Moreover, not only "psychological terror" takes place, as Professor LB Likhterman (1996) notes, but sometimes there is also a physical effect on the doctor.

The above complicates the relationship between the doctor and the patient. The doctor is increasingly meeting with patients who are usually called "difficult" (anxious, hysterical, with psychopathological disorders), characterized by the presence of various functional disorders in them.

So, according to the Center for Behavioral Neurology, Brain Research Institute named after N.P. Bekhtereva such functional disorders are observed in 31% of rheumatological patients, 42% of cardiological, 50% of gynecological and in 55% of neurological patients [1].

A characteristic feature of these patients is a high prevalence of psychoemotional problems:

• a higher overall level of psychological distress;

• more pronounced emotional experiences [11].

The frequency of psychological traumas in patients with functional disorders is 2.7 times higher than in the group of patients with them.

10-20% of such patients have mood disorders, depression, in 15-25% – anxiety, irritability, and discontent [7].

The knowledge of the above is also important for the anesthetist both in communicating with patients hospitalized for selective or urgent surgical intervention, and in ICU conditions.

It should be noted that the morality and behavior of each patient, along with his uniquely individual personal qualities, is also determined by general laws. Among them functions, types, systems and communication models should be considered.

Communication functions. There are several interconnected communication functions: informational, interactive, perceptual, emotive (affective-communicative).

The information (communicative) function provides for the exchange of information between interacting individuals.

The interactive function of communication consists in regulating behavior and the direct organization of joint efforts in the process of interaction between the doctor and the patient.

The perceptual function of communication is characterized by a process of mutual perception and cognition of each other.

The emotional (affective-communicative) communication function consists in regulating the emotional sphere of both communication participants: the doctor and the patient [11].

Based on the goals, the following levels of communication are distinguished:

• social-role (ritual) level aims to achieve the expected role from the interlocutor based on knowledge of the social environment and the rules of behavior;

• business level aims to achieve a joint effort in the implementation of joint work;

• intimate-personal level has the goal of achieving psychological closeness, patient's confidence in the doctor by satisfying his need for sympathy, understanding, empathy.

Types of communication. The knowledge of the possible types of communication between the doctor and the patient is not less important. There are three types of communication:

• imperative communication, which is characterized by the open desire of the doctor to submit the patient, to control his behavior and thoughts, to force him/her to certain actions;

• manipulative communication is characterized by the latent influence of the doctor on the patient in order to establish control over his/her behavior using various methods of manipulation;

• dialogical communication is based on the equal rights of the partners. It resists the first two types of communication [6].

Communication systems. In the process of communication between the doctor and patients, depending on the circumstances, two communication systems can be used: verbal and non-verbal.

The verbal (verbal) communication system is based on speech in its various forms.

The non-verbal communication system is based on facial expressions, gestures and other body movements.

Communication Models. The American philosopher, specialist in bioethics Robert Witch (quoted by L.S. Chutko, 2018) draws attention to the need to use one or another communication model in communicating with a patient. In the "doctor-patient" relationship, he identifies 4 models: paternalistic, technocratic, collegial and contractual.

The most commonly used is paternalistic (sacral) model of interpersonal relationships, which is similar to the relationship of father and child, mentor and ward, based on mercy, care, where all responsibility lies with the doctor.

Within the technocratic (engineering) model, the patient is perceived by the doctor as a faceless mechanism. The patient is not involved in the discussion of the treatment process.

The collegial model of communication is built on the principle of equality, and the contract model on the principles of the contract.

Each patient requires an individual approach, individual forms of communication and measures of medical psychotherapeutic influence, especially in the doctor's communication with the so-called difficult patients, as well as at the risk of developing conflict situations [4].

Anxious patients. Anxiety is an individual psychological feature, manifested by a tendency to anxiety. As a rule, such patients have a low threshold of occurrence, which may be accompanied by somatic manifestations, primarily vegetative hyperreactivity.

Normal and pathological anxiety are distinguished. Normal (adaptive) anxiety can be the result of emotional discomfort, as a response to an uncertain or threatening situation. It is a short-lived, moderate in nature and does not interfere with the productive activity of the patient.

Pathological anxiety is characterized by an excessive attitude of the patient to the situation that caused it, may be due to individual external factors. It develops sequentially, lasts longer, being accompanied by decline in the quality of life. These patients are fussy, constrained, overstressed, exaggerate complaints and their dangers, can be irritable, aggressive, and show hostility while speak with a doctor [5].

When dealing with anxious patients, the doctor should show attention and tolerance, interest in treating such a patient, explain the relationship between anxiety and physical well-being, treatment plan and the meaning of the procedures, explain how to behave in a potentially disturbing situation, and avoid iatrogenic and vague statements.

Patients with severe maladjustment due to pathological anxiety should be consulted by a psychiatrist.

Patients with hysterical disorders.

Hysterical personalities are distinguished by the eccentricity of their external behavior; they have a history of treatment by many doctors for a variety of somatic disorders. They have extremely high requirements to the others, underestimate or completely ignore objective real conditions.

Personal characteristics of such patients are characterized by immaturity, demonstrativeness, a tendency to hypercompensatory response. Another feature of hysterical behavior of these patients is

presenting himself/herself as a powerless and dependent being, eager for care and attention.

Manifestations of hysteria can be mental (loss of memories, fears, narrowing of consciousness, hallucinations); motor (paralysis, paresis, spasms, seizures, gait disturbance, hyperkinesis); sensory (blindness, deafness, hypo- or hyperesthesia); autonomic-somatic (disorders of the cardiovascular activity, respiration, gastrointestinal tract, genitourinary system).

These patients usually require not only increased attention, but also attention of a specialist, extremely careful care [11].

When communicating with a patient of this category, the doctor should constantly monitor his feelings, gestures, words. V.V. Solozhenkin notes [9]: "A doctor can make one wrong gesture, say one careless word, utter one unsuccessful expression and this can cause distrust towards him. Do not forget that our patients hear what they want, and not what we say."

It is necessary to maintain a certain psychological distance, which guarantees the doctor a certain degree of safety regarding possible manipulations by the hysterical patient [8].

Patients with psychosomatic disorders.

Even Hippocrates expressed the idea of a connection between bodily and mental illnesses, and in the nineteenth century the German physician Heinroth introduced the concept of "psychosomatic illness", indicating the relationship between bodily illnesses of patients and their mental experiences.

Psychosomatic disorders develop on the basis of the interaction of mental and somatic factors and can be manifested by somatization of mental disorders or mental disorders that reflect a reaction to a somatic disease.

In clinical practice, three main levels of somatization have been distinguished: bodily sensations, cognitive level, when the understanding and interpretation of symptoms is considered by patients in terms of threats to their health, and the behavioral level, when the patient's actions and his social connections follow from the interpretation of his own feelings. The limited ability to perceive our own emotions and feelings causes emotional stress with its transformation into pathological physiological reactions. Visual-effective thinking in this category of patients prevails over abstract-logical, which is characterized by excessive practicality, difficulties and conflicts in interpersonal and especially official relations, with short-term, but sharply expressed in behavior affective breakdowns poorly understood by the patients themselves. All this makes difficulties in communication of a doctor with such patients.

The personal qualities of patients with psychosomatic disorders are represented by an excessive desire to achieve success and recognition, excessive control over the situation, increased aggressiveness and impatience, which leads to the appearance of exaggerated demands on both themselves and others. Long-term stress causes the formation of anxiety-depressive disorder in them.

Psychosomatic disorders are most often manifested by the development of a psycho-vegetative syndrome. When communicating with a doctor in such cases, when collecting an anamnesis, one should pay attention to the circumstances of the patient's life in which this syndrome arose and its connection with the real environmental factors, which will help to better understand the relationship between the severity of functional symptoms and the emotional background. A calm and friendly attitude towards such a patient should be shown, as well as understanding of his condition and his discomfort. Patients in this group need compassion and sympathy more than others, since functional pathology causes them real and tangible suffering.

In medicine, as in an area affecting the interests of each person - life and health there are conflicts in which people can cross reasonable boundaries in protecting their interests. If previously a conflict situation was developed only in the personal communication of the doctor and the patient with the involvement of the administration of the medical institution as an arbiter, then now more and more cases of mutual misunderstanding end in court [3, 12].

Conflicts are based on the characteristics of interpersonal relations, due to the difference in personal qualities of people, their values and beliefs.

Conflicts can arise due to the personality characteristics of the doctor and the patient, especially in cases of communication with patients with functional disorders [1, 12].

Causes of conflict:

• insufficient attention to the patient;

• characterological features of the doctor and patient;

• leakage of inaccurate information about the patient's state of health on the part of nursing staff and mid-level medical personnel;

• lack of informational consent of the patient for treatment;

• lack of coordination among doctors of different specialties;

• defects in keeping medical records;

• professional incompetence [13, 14].

Interacting with a patient, understanding of the patient's problem should be shown, regardless of the

form of its presentation. Perhaps the situation has a simple solution and can be easily overcome.

You should not take the patient's emotional statements personally and respond to provocations. It is necessary to defend one's position without showing arrogance and aggression, striving to develop a mutually beneficial solution to the conflict situation on the basis of cooperation and compromise. After overcoming a conflict situation, lessons should be learned from it.

However, the best way to overcome the conflict is to prevent it from arising.

The interaction between the doctor and the patient in the course of treatment is one of the main components of success, because the established relationship between them not only eliminates certain difficulties, which, on the one hand, worsen the patient's condition, and on the other, negatively affect the doctor, but they themselves are healing, as this strengthens and facilitates the interaction of all other therapeutic measures, levels the conditions for the development of conflict situations.

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